



HIPAA Release Authorization

I, _____, hereby authorize my physicians, nurses, home care agency, and all other health care providers and their staff (collectively, "health care providers") involved in my health care treatment, to release information regarding my location, medical condition, diagnosis and prognosis, as well as any other information about me, to include individually identifiable health information, and to freely converse and communicate, both orally and in writing, with the persons named below.

This document does not grant health care decision-making authority and does not in any way affect, inhibit, or otherwise limit the authorization granted in any existing health care power of attorney that I may have executed.

This document, executed by me pursuant to the Health Insurance Portability and Accountability Act of 1996, is effective immediately and is not to be affected by any subsequent incapacity.

I hereby release the disclosers of the above information from any liability for its release to the persons below. This authorization shall be in force and effect only for a period of one year from the date signed, below. The persons to whom my health care providers may disclose the above information, including individually identifiable health information, are:

The PA Foundation for Home Care and Hospice
and any of its employees or representatives
600 N. 12th Street, Suite 200, Lemoyne, PA 17043
Phone: 717-975-9448

AND

Name: _____ Phone: _____

Address: _____

AND

Name: _____ Phone: _____

Address: _____

Client/Representative Signature

Date

Witness Signature

Witness Printed Name



Financial Affidavit

Date: _____

County: _____

State: _____

Client/Affiant (Full Legal Name): _____

I, the undersigned, _____, who is a resident of _____ County, State of _____, makes this his/her statement and General Affidavit upon oath and affirmation of belief and personal knowledge that the following matters, facts and things set forth are true and correct to the best of his/her knowledge: I certify that _____, the applicant for home health care services, has a total personal monthly income that does not exceed \$5,000 (single) or \$10,000 (dual income, including spouse/partner, excluding any child income*), in accordance with the guidelines and service criteria defined by the Pennsylvania Foundation for Home Care and Hospice's Home Care Grant program. Furthermore, I certify that the applicant for home health care services is not currently receiving similar services through a Pennsylvania Medicaid Waiver Program nor is the applicant a veteran receiving similar services through the Veterans Affairs' Aide and Assistance Program or similar program.

Client/POA Signature

Date

Witness Signature

Witness Printed Name



Home Care Grant

Client Information and Care Plan

Client Demographics	
Name _____ Phone _____ DOB _____ Address _____ Emergency Contact _____ Relationship _____ Email _____ Phone _____ PCP Name _____ Phone _____	
Planned Frequency of In-Home Care Services <i>(subject to change by customer request)</i>	
Care to be delivered in increments of _____ hours per _____ <i>(i.e. 2 hrs/week)</i>	
Type of Service/Care Requested	
Personal Care <input type="checkbox"/> Toileting <input type="checkbox"/> Incontinence Care <input type="checkbox"/> Bathing <input type="checkbox"/> Grooming <input type="checkbox"/> Lifting/Transfer Assistance <input type="checkbox"/> Ambulation Assistance <input type="checkbox"/> Medication Reminders Other _____	Homemaker <input type="checkbox"/> Meal Preparation <input type="checkbox"/> Housekeeping <input type="checkbox"/> Laundry <input type="checkbox"/> Transportation Skilled Care <input type="checkbox"/> Skilled Assessment/Observation <input type="checkbox"/> Medication Adherence/Management <input type="checkbox"/> Disease Management <input type="checkbox"/> Patient Education
Reason for Care Need	
<i>Check all that apply:</i> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Decline in Health Status <input type="checkbox"/> Hospitalization within 30 days <input type="checkbox"/> Discharge from LTCF within 30 days <input type="checkbox"/> Other: _____ </div> <div style="width: 45%;"> <input type="checkbox"/> Supplementing private pay services <input type="checkbox"/> Waiting for funding approval or renewal through: _____ </div> </div>	
Other Current In-Home Services	
<i>Check all that apply:</i> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Meals on Wheels <input type="checkbox"/> Other funded skilled Home Health Care <input type="checkbox"/> Other funded non-medical Home Care </div> <div style="width: 45%;"> <input type="checkbox"/> Personal Emergency Response System <input type="checkbox"/> Telehealth <input type="checkbox"/> Other: _____ </div> </div>	

Client, representative and agency must notify The Foundation immediately if another funding source for home care services becomes available while active with The Foundation's Home Care Grant.